

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS5046AGC	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/17/2009
NAME OF PROVIDER OR SUPPLIER OHANA ADULT CARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1566 MT HOOD ST LAS VEGAS, NV 89110		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 000	<p>Initial Comments</p> <p>The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws.</p> <p>This Statement of Deficiencies was generated as a result of an annual State Licensure survey conducted at your facility on 6/17/09. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division.</p> <p>The facility was licensed for 10 Residential Facility for Group beds which provide care to persons with Alzheimer's disease, Category II residents. The census at the time of the survey was 6. Six resident files were reviewed and 3 employee files were reviewed. One discharged resident file was reviewed. The facility received a grade of A.</p> <p>The following deficiencies were identified:</p>	Y 000		
Y 103 SS=F	<p>449.200(1)(d) Personnel File - NAC 441A</p> <p>NAC 449.200 1. Except as otherwise provided in subsection 2, a separate personnel file must be kept for each member of the staff of a facility and must include: (d) The health certificates required pursuant to chapter 441A of NAC for the employee.</p> <p>This Regulation is not met as evidenced by: Based on record review on 6/17/09, the facility</p>	Y 103		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS5046AGC	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/17/2009
NAME OF PROVIDER OR SUPPLIER OHANA ADULT CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1566 MT HOOD ST LAS VEGAS, NV 89110		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
Y 103	Continued From page 1 failed to ensure 1 of 3 caregivers complied with NAC 441A.375 regarding tuberculosis testing (Employee #3) for the protection of 6 of 6 residents. Severity: 2 Scope: 3	Y 103			
Y 435 SS=F	449.229(4) Fire Extinguisher; Inspection NAC 449.229 4. Portable fire extinguishers must be inspected, recharged and tagged at least once each year by a person certified by the State Fire Marshall to conduct such inspections. This Regulation is not met as evidenced by: Based on observation on 6/17/09, the facility failed to ensure 1 of 1 facility fire extinguishers were inspected annually. Severity: 1 Scope: 3	Y 435			
Y 936 SS=F	449.2749(1)(e) Resident file NAC 449.2749 1. A separate file must be maintained for each resident of a residential facility and retained for at least 5 years after he permanently leaves the facility. The file must be kept locked in a place that is resistant to fire and is protected against unauthorized use. The file must contain all records, letters, assessments, medical information and any other information related to the resident, including without limitation: (e) Evidence of compliance with the provisions of	Y 936			

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS5046AGC	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/17/2009
NAME OF PROVIDER OR SUPPLIER OHANA ADULT CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1566 MT HOOD ST LAS VEGAS, NV 89110		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
Y 936	<p>Continued From page 2</p> <p>chapter 441A of NRS and the regulations adopted pursuant thereto.</p> <p>This Regulation is not met as evidenced by: Based on record review on 6/17/09, the facility failed to ensure 4 of 6 residents complied with NAC 441A.380 regarding tuberculosis (Resident #1, #2, #3 and #6) which affected all residents.</p> <p>Severity: 2 Scope: 3</p>	Y 936			

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.